EDITORIAL

# Quality accounts, quality indicators, QIPP and tissue viability: time to act

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The focus on national targets in healthcare delivery is now at an end. The new mantra is one of quality, combined with innovation, productivity and prevention (QIPP); (Department of Health [DoH], 2008a; Nicholson 2009). This has been described as 'the new landscape in which we operate' (Farrar, 2009). An integral part of the QIPP initiative is the requirement to provide a 'quality account', as set out in the recent framework document (DoH, 2009a). From April 2010, all providers of healthcare services in England (under the auspices of the NHS) will be required to provide a quality account (DoH, 2009a).

This exercise is of paramount importance for all major service providers, especially tissue viability, as it will serve to establish the central role, services and standards of the speciality in the NHS. This is currently a nurse-led speciality with a relatively low profile – both publicly and within the healthcare system. The problem lies with the indistinct perception of what tissue viability entails, and the cost of typical disorders such as pressure ulcer treatment and prevention, leg ulceration, aspects of skin care and protection of 'at-risk' skin to the NHS. Nowhere is this confusion more evident than in the second Darzi report (Darzi, 2009), where a lack of expert tissue viability input has led to a seriously flawed report (White and Cutting, 2009a, b). While no consensus exists on what constitutes tissue viability, it is reasonable to include the management of acute and chronic wounds, pressure ulcer prevention, infection control with respect to wounds, and the protection of skin at risk from trauma, incontinence and infection (White, 2008). The cost of these problems to the NHS has been estimated to be of the order of £2–4 billion per annum, a figure which is generally not widely recognised (Posnett and Franks, 2007; White, 2008). Recent audits at trust level have provided detailed breakdown of the clinical requirements (Vowden et al, 2009). The extrapolation of local costs derived from these audits supports the published figures for national costs.

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Given the nature and cost of tissue viability, what then is important for the QIPP (quality, innovation, productivity, prevention) initiative, the preparation of quality accounts, and for commissioners?

The DoH (1998) introduced a consultation document which will lead to legislation requiring the publication of quality accounts from April 2010. In preparation for this, some NHS foundation trusts and healthcare providers have already prepared and submitted their accounts. The very nature of these reports relates to the quality and standards of care that are provided by practitioners involved in tissue viability and wound care.

The disclosure of information relating to quality is by no means new (DoH, 1998). However, Marshall et al (2000) commented that public disclosure is advocated by some proponents with great enthusiasm, but often with no clear conceptualiasation of its purpose or implications. Indeed, Bero et al (1998) remarked that using performance data for internal audit purposes had not resulted in the anticipated change in clinical practice or consistent improvements in quality of care. This clearly identifies the urgency and importance of the tissue viability community responding to the quality accounts consultation.

The DoH (2008a) stated that by selecting treatment that is appropriate to the cause and the condition of the wound, healthcare professionals will improve their performance against 'quality at the heart of everything we do' (DoH, 2008a, p.11), which identified the following domains of importance:

- Patient safety
- Patient experience
- Effectiveness of care.

Integral to this was the importance of bringing clarity to quality, measuring quality, publishing quality, raising quality performance, recognising standards, raising standards, safeguarding quality and staying ahead. The second report, *Transforming Community Services* (Darzi, 2009), stressed the importance of 'getting the basics right — every time'. Yet, as White and Cutting (2009a, b) identify, while tissue viability does get a mention, sadly it amounts to no more than 100 words.

Inherent in producing the quality accounts is the need for the results to relate to QIPP. Chief executive officers (CEOs) and chief nurses are reliant on accurate information of the quality indicators for their to be able to meet the requirements on their directed agenda. QIPP is about creating

an environment in which change and improvement can flourish; it is about leading differently and in a way that fosters a culture of innovation; and it is about providing staff with the tools, techniques and support that will enable them to take ownership of improving quality of care (Taylor, 2009).

Careful consideration is needed to design metrics that can be used effectively to attain this information. These can include patients' views on the success of treatments and of the quality of the services they are given; patient reported outcome measures (PROMS; DoH, 2009b) and of their experience, patient safety, clinical-effectiveness of interventions, incidence and prevalence monitoring of pressure ulceration, infection rates, product usage, costs, safety issues and the impact of education. Thought must be given to ensuring that each healthcare provider has a wound care formulary that is designed using robust supporting evidence, audited at regular intervals and revisited to ensure that new evidence and new product developments are recognised and implemented.

In summary, tissue viability is advancing rapidly towards achieving the necessary requirements for QIPP. In spite of the flaws in the second Darzi report, there is a tacit acknowledgement that tissue viability is an essential service. However, greater recognition at both national and trust levels is required in order to maintain services.

Clinical nurse specialists are central to practice development and must be provided with the framework in which they can bring about changes in practice (Austin et al, 2009). This is your opportunity to make a difference and to develop a framework that meets the needs of the tissue viability community. We must identify it as a specialty that promotes recognition of the therapeutic value that expert care can bestow on patients, and at the same time have a positive impact on cost-effectiveness, as well as the authority to enact changes in practice (Cutting and White, 2009; White and Cutting, 2009a, b).

To ensure a clear and consistent message of quality is delivered and understood, it is vital that all relevant parties are encouraged to engage in this project. Certain non-clinical skills can be sought from industry, including project management and marketing. Indeed, the DoH has set best practice guidance on joint working between NHS and commercial organisations (DoH, 2008b). 'Joint working' with industry should be constructed in a manner that is open and transparent. This should be encouraged to enable a stronger proposition to be put forward. It is welcoming to see that companies like Smith & Nephew have embraced the concepts mentioned in this article and proactively engage with their customers on the national policies and drivers associated with quality accounts. The QIPP initiative is so important for tissue viability, now and in the future, that all available resources must be channelled into a response to the quality accounts framework document, and in securing the future of the speciality. WUK

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